NUTRITION QUESTIONNAIRE FOR ADOLESCENTS AGES 11 TO 21

1. Which of these meals or snacks did you eat yesterday?
(*Check all that apply*)

- ☐ Breakfast
- ☐ Lunch
- ☐ Dinner or supper
- ☐ Morning snack
- ☐ Afternoon Snack
- ☐ Evening/late-snack

2. Do you skip breakfast 3 or more times a week?

☐ Yes ☐ No

Do you skip lunch 3 or more times a week?

☐ Yes ☐ No

Do you skip dinner or supper 3 or more times a week?

☐ Yes ☐ No

3. Do you eat dinner or supper with your family 4 or more times a week?

☐ Yes ☐ No

4. Do you fix or buy the food for any of your family's meals?

☐ Yes ☐ No

5. Do you eat or take out a meal from a fast food restaurant 2 or more times a week?

☐ Yes ☐ No

6. Are you on special diet for medical reasons?

☐ Yes ☐ No

7. Are you a vegetarian?

☐ Yes ☐ No

8. Do you have any problems with your appetite, like not feeling hungry, or feeling hungry all the time?

☐ Yes ☐ No

9. Which of the following did you drink last week?*(Check all that apply)*

- ☐ Tap or bottled water
- ☐ Fitness water
- ☐ Juice
- ☐ Regular soft drinks
- ☐ Diet soft drinks
- ☐ Fruit-flavored drinks
- ☐ Sport drinks
- ☐ Energy drinks
- ☐ Recovery drinks
- ☐ Fat-free (skim) milk
- ☐ Low-fat (1%) milk
- ☐ Reduced-fat (2%) milk
- ☐ Whole milk
- ☐ Flavored milk (for example, chocolate, strawberry)
- ☐ Coffee or tea
- ☐ Beer, wine, or hard liquor

10. Which of these foods did you eat last week?
(*Check all that apply*)

Grains:

- ☐ Bagels
- ☐ Bread
- ☐ Cereal/grits
- ☐ Crackers
- ☐ Muffins
- ☐ Noodles/pasta/rice
- ☐ Rolls
- ☐ Tortillas
- ☐ Other grains:……..

Vegetables

- ☐ Broccoli
- ☐ Carrots
- ☐ Corn
- ☐ Green beans
- ☐ Green salad
- ☐ Greens (collard, spinach)
- ☐ Peas
- ☐ Potatoes
- ☐ Tomatoes
- ☐ Other vegetables……

Fruits

- ☐ Apples/ juice
- ☐ Bananas
- ☐ Grapefruit/juice
- ☐ Grapes/juice

- ☐ Melon
- ☐ Oranges/juice
- ☐ Peaches
- ☐ Pears
- ☐ Other fruits/juice:……

Milk and Milk Products

- ☐ Fat-free (skim) milk
- ☐ Low-fat (1%) milk
- ☐ Reduced-fat (2%) milk
- ☐ Whole milk
- ☐ Flavored milk
- ☐ Cheese
- ☐ Ice cream
- ☐ Yogurt
- ☐ Other milk and milk products: ……

Meal and Meal Alternatives

- ☐ Beef/hamburger
- ☐ Chicken
- ☐ Cold cuts/deli meals
- ☐ Dried beans (for example, black beans, kidney beans, pinto beans)
- ☐ Eggs
- ☐ Fish
- ☐ Peanut butter/nuts
- ☐ Pork
- ☐ Sausage/bacon
- ☐ Tofu
- ☐ Turkey
- ☐ Other meal and meat alternatives:……

Fats and Sweets

- ☐ Cake/cupcakes
- ☐ Candy
- ☐ Chips
- ☐ French fries
- ☐ Cookies
- ☐ Doughnuts
- ☐ Fruit-flavored drinks
- ☐ Pies
- ☐ Soft drinks
- ☐ Other fats and sweets: ……..

11. Do you have a working stove, oven, and refrigerator where you live?

☐ Yes ☐ No

12. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?

☐ Yes ☐ No

13. Are you concerned about your weight?

☐ Yes ☐ No

14. Are you on a diet now to lose weight or to maintain your weight?

☐ Yes ☐ No

15. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pill or laxatives, or not eating?

☐ Yes ☐ No

16. Did you participate in physical activity (for example, walking or riding a bike) in the past week?

☐ Yes ☐ No

If yes, on how many days and for how many minutes or hours per day?.....

17. Did you spend more than 2 hours per day watching television and DVDs or playing computer games?

☐ Yes ☐ No

If yes, how many hours per day?.....

18. Does the family watch television during meals?

☐ Yes ☐ No

19. Do you take vitamin, mineral, herbal, or other dietary supplements (for example, protein powders)?

☐ Yes ☐ No

20. Do you smoke cigarettes or chew tobacco?

☐ Yes ☐ No

21. Do you ever use any of the following? *(Check all that apply)*

- ☐ Alcohol, beer, or wine
- ☐ Steroids (without a doctor's permission)
- ☐ Street drugs (marihuana, speed, crack, or heroin)